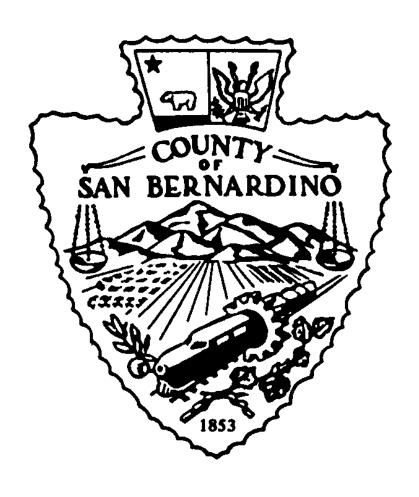
## Reporting Procedures



### County of San Bernardino RISK MANAGEMENT DIVISION/HUMAN RESOURCES

### **REPORTING PROCEDURES**

For

OCCUPATIONAL INJURIES AND ILLNESSES

MODIFIED DUTY

VEHICLE ACCIDENTS

PROPERTY DAMAGE

CLAIMS AGAINST THE COUNTY

PERSONAL PROPERTY CLAIMS

VIOLENCE IN THE WORKPLACE

BLOODBORNE PATHOGEN PROGRAM

September 2000

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### REPORT FORMS TO USE

- Earthquake/Fire/Glass Breakage/Vandalism/Malicious Mischief/Flood Damage, disappearance or theft of County Property, money or securities.
  - To a vehicle, use Incident Report Form (No. 15-13866-000 Rev. 1-94).
  - b. To other County or District property, monies or securities. Always obtain police report for monies loss, vandalism or malicious mischief. Use Incident Report Form (No. 15-13866-000 Rev. 1-94) and indicate "Other Accident."

### 2. Vehicle Incident.

- a. With injury to County employee or volunteer, use three forms, Employee's Claim For Workers' Compensation Benefits (Form No. 07-633-000 Rev. 1/94), Employer's Report of Occupational Injury or Illness (Form No. 15-14248-000 Rev. 6/98), the Incident Report (Form No. 15-13866-000 Rev. 1/94), and Vehicle Accident Report (Form No. 15-5704-000 Rev. 1/94).
- b. Without injury to County employee or volunteer, use only the Incident Report (Form No. 15-13866-000 Rev. 1/94), and Vehicle Accident Report (Form 15-5705-000 1/94).

### 3. Occupational Injury or Illness, Employee, Volunteer or Juror.

- a. First Aid only, no doctor, clinic or hospital visit, or lost work time, use First Aid Record for notation.
- b. If doctor, clinic or hospital is visited, send a copy of the Medical Service Order (16-13212-000 Rev. 11/93) with the employee when he or she seeks treatment.
- c. If doctor, clinic or hospital is visited, or there is lost time from work, an Employee's Claim For Workers' Compensation Benefits (Form No. 07-633-000 Rev. 1/94) and Employer's Report of Occupational Injury or Illness (Form No. 15-14248-000 Rev. 6/98) must be completed.

### 4. Non-County Personal Injury/Property Damage.

- a. Non-employee, use Incident Report Form (No. 15-13866-000 Rev. 1/94).
- b. Non-County property damage, use Incident Report Form (No. 15-13866-000 Rev. 1/94).

### 5. Claims Against the County.

- a. If the incident or accident is unknown to you or your department and a party is requesting reimbursement for damages, the complainant should fill out Claims Against the County of San Bernardino Form (No. 07-8387-286). (Obtain copies of form from Risk Management, Liability Section, (909) 386-8631, or refer the party to Risk Management, 222 W. Hospitality Lane, 3rd Floor, San Bernardino Ca 92415-0016, to obtain a form.
- b. If you or your department are aware of the incident and an employee witnessed the incident, please contact Risk Management Division. Submit an Inter-Office Memo to Risk Management explaining the claim and if you feel the claim is valid or not.

### 6. Personal Property Claim (Employee).

Loss or damage to employee's personal property is reimbursable if the loss was caused by peculiar circumstances, and not caused by the employee's own negligence. Eligible employees should submit the Personal Property Claim (Employee) Form (No. 07-13351-000 Rev. 2/94).

### 7. Hazard Report.

To report a hazardous condition, piece of equipment or unsafe procedure, submit the Hazard Report Form (No. 15-18582-000).

### 8. Violence in the Workplace Incident.

To report a violence in the workplace incident, use Workplace Threat Incident Against County of San Bernardino Employee (Form No. 10-299964) and County of San Bernardino Workplace Threat Mitigation Report (Form No. 15-199965-000).

### 9. Bloodborne Pathogen Exposure Incident.

To report a Bloodborne pathogen exposure use Bloodborne Pathogen & Tuberculosis Exposure Report (Form No. 15-19418-000 Rev. 6/01).

### 10. Hepatitis B Virus Immunization.

Use Hepatitis B Vaccine Authorization (Form No. 04-19404-000 *or* Hepatitis B Vaccine Declination (Form No. 04-19403-000).

NOTE: All forms are to be submitted to the Risk Management Division, 222 W. Hospitality Lane, 3rd Floor, San Bernardino CA 92415-0016. If your department or group has its own reporting procedures, these procedures are to be adhered to: however, all report forms must be submitted in a timely manner. If you have any questions call Risk Management at (909) 386-8655 for the Workers' Comp. Section, (909) 386-8631 for the Liability Claims Section and (909) 386-8623 for the Safety Section.

### GENERAL REPORTING INFORMATION

All occupational injuries or illness necessitating medical treatment must be reported to Risk Management Division within 24 hours via fax. All other accidents or injuries must be reported to the Risk Management Division, within 48 hours on the appropriate form. Serious vehicle accidents are to be reported by phone to Risk Management at (909) 386-8624. After hours, call Comm Center at (909) 356-3811. Incomplete or unsigned forms will be returned to the originator. Claims for reimbursement for damage or loss of County property or monies and/or securities are to be reported immediately to Risk Management after calling the local law enforcement agency. A police report is required and all suspects are to be prosecuted.

If the injury to the County employee, juror or volunteer results in death, amputation of a limb, finger or toe up to the first joint, or severe injury to any part of the body, the injury must be reported Immediately by phone to the Risk Management Division, (909) 386-8655 or (909) 386-8624 or call Comm Center at (909) 356-3811. Risk Management will report to the Department of Industrial Relations, Division of Occupational Safety and Health as required by law.

If your group or department has developed its own reporting procedures, these are to be adhered to; however, all report forms included herein must be submitted in a timely manner to Risk Management.

Departments and Districts are responsible for keeping Risk Management advised of the status of employees, volunteers or jurors who are off work as a result of an occupational injury or illness. All off work orders are to be faxed to Risk Management at (909) 386-8711 or 386-8670. Original copies of off work orders or other pertinent paperwork should then be sent to Risk Management by Interoffice Mail or regular mail. Prompt notification eliminates overpayment of compensation benefits. If there is a recurrence of the injury or illness, the Risk Management Division is to be advised immediately so compensation may be resumed, if necessary. Also Risk Management personnel will need to determine whether this is actually a recurrence or a new injury which may require a new claim to be filed.

Outlined below are situations which require immediate notification of Risk Management:

1.	Dangerous conditions that are an immediate	10.	Thefts of County property, money or
	hazard to employees or the public.		securities.
2.	Fires.	11.	Major accidents/fatal accidents.
3.	Explosions.	12.	Major injuries/illnesses, fatal injuries/
4.	Earthquakes.		illnesses.
5.	Bomb threats.	13.	All Cal/OSHA inspections or contracts.
6.	Power outages.	14.	Building evacuations.
7.	Sewage spills.	15.	Outbreaks of illness with three or more
8.	Flooding.		employees (excluding flues and colds).
9.	Threats to or violence toward County	16.	All employee driver license revocations/
	employees.		suspensions.
	• •	17.	All employee DUI's.

### OCCUPATIONAL INJURY OR ILLNESS TO AN EMPLOYEE, JUROR OR VOLUNTEER

### First Aid Only:

If an employee does not lose time from work, see a doctor, clinic or hospital, enter the name of the employee, the nature of injury, the cause of the injury and your signature (must be a supervisor's signature, or person left "in charge" during that time period) on the "First Aid Record" which is retained by your department (see instructions reverse side of "First Aid Record" form). This form should be kept with your First Aid Kit. It is used to document minor injuries incurred during employment that do not require medical treatment from a doctor, clinic or hospital. An employee is not required to seek medical treatment for an occupational injury or illness.

### Medical Treatment Injury:

Forms needed: Employer's Report of Occupational Injury or Illness

5020 (Form No. 15-14248-000 Rev. 6/98);

**Employee's claim for Workers' Compensation Benefits** 

DWC-1 (Form No. 07-633-000, Rev. 1/94);

Medical Service Order (Form No. 16-13212-000, Rev. 11/93)

The employer is required to provide an "Employee's Claim for Workers' Compensation Benefits" (Form No. DWC-1) within 24 hours of notification to the department or district of an occupational injury or illness, or upon demand by the employee. Upon receipt of the completed form from the employee, the supervisor is to date and sign the form and immediately return a dated copy to the injured employee within 24 hours or a \$5000 fine can be levied against your department. A copy of this form is then faxed to Risk Management (or, for HSS employees, faxed to HSS Personnel) immediately or at least within 24 hours at (909) 386-8711. The original and one dated copy are then mailed to Risk Management, (or, for HSS employees, mailed to HSS Personnel), Interoffice Mail. Please refer to the instructions for completing this form on the following pages.

The department designee should then complete the "Medical Service Order For Occupational Injury or Illness" (Form 16-13212-000, Rev. 11/93), keep a copy for their records, and give it to the employee to take with them to either a doctor or medical facility from the County Medical Referral List for Occupational Injuries, or if the employee has submitted a "Request to see Personal Physician" prior to the injury, and Risk Management has this form on file, they may be referred to this doctor. A copy of the Medical Service Order form should also be faxed to Risk Management immediately. The employee presents the original form to the doctor for completion, the doctor should then complete the bottom section, keep a copy for the chart record, and return the completed form to the employee. The employee is to return this form to their department supervisor, or other designee to advise the department of the employee's medical status. Please refer to the instructions for completing this form on the following pages.

The department designee (<u>not</u> the injured employee), shall complete four copies of the "Employer's Report of Occupational Injury or Illness" form. If additional space is needed to clarify information on this form, please attach this information on a separate sheet of paper. Please refer to the instructions for completing the form on following pages.

A copy of each of these forms should be faxed immediately to Risk Management at (909) 386-8711. Only one signature is necessary on the "Employer's Report of Occupational Injury or Illness in order for it to be faxed to Risk Management--again, this cannot be the injured employee's signature.

The originals and copies, as per the distribution indicated on each form, should be sent to Risk Management following the procedures your own group or department may have already in place for additional review and/or needed signatures. Copies of these forms should be retained by the department for their records.

### **County of San Bernardino**

### WHAT TO DO IN CASE OF ACCIDENT ON COUNTY PREMISES TO VISITING PUBLIC

This form is to be posted at each County work location on your bulletin board. Call 9-1-1 throughout San Bernardino County for immediate response from the proper Law Enforcement Agency.

Call Risk Management at (909) 386-8631 if you have any questions.

### COUNTY OF SAN BERNARDINO

### WHAT TO DO IN CASE OF ACCIDENT ON COUNTY PREMISES TO VISITING PUBLIC

### TO ALL EMPLOYEES:

- 1. Perform necessary first aid if you are trained to do so such as stopping bleeding, restoring breathing, treating for shock and other First Aid necessary to maintain life and prevent further injury.
- 2. Advise the injured person to proceed as he would for an injury in his residence, calling his preferred doctor or hospital.
- 3. If the injured person has no preferred doctor or hospital, or cannot respond, and must be taken to a hospital or emergency clinic, proceed as follows:
  - A. If the accident has occurred in a County building which is located within the city limits, call the local city police and request an ambulance. Give detailed instructions on how to reach your building and tell them where someone will be waiting to guide them to the injured person.

Local City Police - Phone No. 9-1-1

- B. If the accident has occurred in a County building which is outside the city limits, call 9-1-1 and request an ambulance. Give detailed instructions on how to reach your building and tell them where someone will be waiting to guide them to the injured person.
- 4. If your building or facility has security guards, they should be alerted that an ambulance is on its way and informed where the injured person is located.
- 5. Send someone to wait for the ambulance at the designated location so the attendants can be guided quickly to the injured person. Do not leave the injured person until the ambulance arrives.
- 6. DO NOT MAKE ANY COMMENT CONCERNING THE INJURY OR COUNTY RESPONSIBILITY OR LIABILITY. Do not move an injured person unless it is required, then use reasonable care during movement. Wait for medical assistance.
- 7. File a report immediately with the County, using County of San Bernardino Other Incident report form available in your department.

Board of Supervisors May, 1998

### **NOTICE TO EMPLOYEES**

This notice must be posted by law at each County work location. It must be posted on your bulletin board with your Cal/OSHA Poster and appropriate summaries.

The bulletin board is to be readily accessible to all employees. All posted notices must remain visible at all times.

### NOTICE TO EMPLOYEES

### IF A WORK INJURY OCCURS...

California law provides certain benefits to employees who are injured or become ill because of the job.

### WORKERS' COMPENSATION BENEFITS INCLUDE...

- MEDICAL CARE. All medical treatment required to cure the injury or illness without cost to the employee. The employee should never see a bill, since all costs are paid directly by the employer or his agent.
- REHABILITATION. If the injury or illness prevents return to the employee's usual job, the employee may receive vocational rehabilitation. Again, all costs are paid by the employer.
- WORKER BENEFITS. Employees disabled by job-injury or job-illness receive income while unable to work. The payments are two-thirds of the employee's average weekly pay, up to a maximum set by State law. (Payments are not made for the first three days of disability unless the employee is hospitalized or unable to work more than 21 days.) Additional payments also will be made after the employee has reached maximum recovery if the injury or illness results in a permanent handicap. If the injury or illness results in death, benefits will be paid to the employee's surviving dependents.

### IN THE EVENT OF A WORK INJURY...

1. Be sure first aid is given.

Effective Jan 1, 1995, employees may use their personal physician if they have notified risk Management in writing before the injury and may change physicians 30 days after the injury.

- 2. The employee's supervisor should take the injured employee to a doctor or hospital, if necessary.
- 3. Report every injury IMMEDIATELY to your supervisor. Any delay in reporting an accident may delay workers' compensation benefits.
- 4. If you have any questions about workers' compensation, please see your supervisor.

### **EMERGENCY TELEPHONE NUMBERS**

SHERIFF/POLICE: 911 PARAMEDICS/AMBULANCE: 911

FIRE: 911 BOMB THREAT: 911

Your employer has received permission from the Director of the Department of Industrial Relations, State of California, to Self-Insure its workers' compensation liabilities under Certificate of Consent to Self-Insure No. P-0127, effective January 1, 1979. This Certificate is valid until revoked.

If you have any questions about your workers' compensation benefits, contact Risk Management Division, (909) 386-8655. If the answer is unsatisfactory, you may call the **Department of Industrial Relations Information and Assistance Center: Toll Free** at any time. The number is (800) 652-1500.

Claims against this employer for workers' compensation benefits should be made by the employee to:

RISK MANAGEMENT DIVISION 222 W. Hospitality Lane, 3<sup>rd</sup> Floor, San Bernardino Ca 92415-0016 (909) 386-8655

### **FIRST AID RECORD**

This form is required by Title 8, California Code of Regulations, General Industry Safety Orders. All injuries or illnesses which do not require medical treatment or lost time from work are logged on this form.

Full forms are to be filed with your OSHA 200 summaries by the supervisor.

The instructions for completion are on the reverse side of the form.

### FIRST AID RECORD FORM

Explanation and Instructions in the purpose and use of the FIRST AID FORM.

Purpose:

- 1. To encourage reporting all work injuries, no matter how minor.
- 2. To insure that each injury receives adequate *FIRST AID* treatment.
- 3. To protect both the injured employee's and the County's interests under the provisions of Workers' Compensation law.
- 4. To enable the injured employee's immediate superior to review each case, to spot trouble conditions and further improve accident prevention measures.

### Instructions:

To Supervisory Personnel: Bring this form to the attention of all your personnel. By the use of a clip board or other device, place this form in a conspicuous space readily available for the use of your personnel. Please be governed by purposes outlined above.

NOTE: If any minor injury later develops into a medical treatment case or lost time case (full day or more), a full report of the incident must be made on an Employee's Claim for Workers' Compensation Benefits and an "Employer's Report of Occupational Injury or Illness." Send a copy of the First Aid Record form that documented the original injury along with the Employer's Report of Occupational Injury or Illness.

### To All Personnel:

Whenever you have a minor injury which does not require medical treatment, report the incident on this form and obtain FIRST AID promptly. Please be governed by the purposes outlined above.

Note:

Additional copies of this form are available from Risk Management Division, Steve Robles, Safety Officer, (909) 386-8623 or can be copied in your office.

\*\*\*Note: KEEP THIS RECORD WITH YOUR PERMANENT FILES

### FIRST AID RECORD

OFFICE:			

Date of Injury	Name of Employee	Nature of Injury (Be Specific)	Cause of Injury	Supervisor Signature
				E/FIRSTAID.DOC

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Form No. 07-633-000 Rev. 1/94

\*\*\*Not To Be Used To Report Exposure To Blood Or Exposure To Body Fluids Or Communicable Disease \*\*\*

May be used only if this exposure results in the employee contracting an illness or disease from such an exposure. Please refer to the instructions for completion of the "Bloodborne Pathogen & Tuberculosis Exposure Report" on page (176) of this manual.

+++

The "Employee's Claim for Workers' Compensation Benefits" form is required by State Law. The use of this form was required effective January 1, 1990. It is stocked at Central Stores.

### THIS CLAIM FORM IS TO BE PROVIDED TO ANY EMPLOYEE WHO:

- 1) Requires medical treatment for an occupational injury or illness.
- 2) Makes a demand for a claim form.
- 3) Has an occupational injury or illness that you have knowledge of (knowledge can be from <u>any</u> source, including a supervisor or other person in authority).

All minor injuries, exposures, etc. that do not require medical treatment or result in lost time from work should be recorded on the "First Aid Record" form - please refer to the instructions for this form on page (142) of this manual. A worker's compensation claim does not need to be filed in this case (You may provide the claim form to the employee, and if an employee still wishes to file a claim, they may do so.).

The claim form must be provided by your department/district to the employee within one working day of your knowledge of an employee's injury or illness (You may also provide service by First Class Mail if the employee is unavailable). The employee is to be instructed to return the completed form to his/her supervisor or alternate as soon as possible.

A \$5000 PENALTY CAN BE ASSESSED IF YOU FAIL TO PROVIDE THIS FORM TO AN EMPLOYEE WITHIN 24 HOURS OF YOUR DATE OF KNOWLEDGE OF THE INJURY/ILLNESS. THE PENALTY IS PAYABLE DIRECTLY TO THE STATE BY YOUR DEPARTMENT, NOT BY RISK MANAGEMENT.

### **⇒**THE TOP OF THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

The supervisor may assist the employee in completing their section of the form if the employee requests, or if the employee is unable to complete the claim form due to hospitalization or severe injury or illness. The form may also be completed by the employee's designated representative (this could be a family member, attorney, etc.). The employee should, however, sign their name on the claim if at all possible. If a claim form must be submitted without this signature, the supervisor, or department should advise Risk Management of the reason when submitting the claim. Since this is a legal document and is admissible in court, the employee's statement on this claim form and their signature attesting to the facts as recorded on the form are very important.

### **▶**UPON RETURN OF THIS FORM BY THE EMPLOYEE OR THEIR LEGAL REPRESENTATIVE, THE DEPARTMENT/DISTRICT MUST FILL OUT THE BOTTOM SECTION OF THE FORM

The supervisor is to write in the date the claim form was received from the employee or his/her designated representative and sign as the "Employer Representative." A copy of the dated form must then be given back to the employee within one working day of receipt. If a dated copy is not provided to the employee, monetary penalties can be imposed by the State.

The supervisor or department designee should record their own statement regarding the circumstances of the injury/illness on the "Employer's Report of Occupational Injury or Illness." This form should be submitted to Risk Management at the same time as the claim form unless special circumstances preclude doing so. If special circumstances exist, please advise Risk Management prior to submitting the "Employers' Report." Instructions for completing the "Employer's Report of Occupational Injury or Illness" are included on page 153 of this manual).

For all Departments other than HSS (which is to FAX all paperwork to HSS Personnel), the "Employee's Claim for Workers' Compensation Benefits" must be FAXED to Risk Management within 48 hours to avoid additional penalties. Risk Management's FAX number's are (909) 386-8711 or 386-8670. After you have FAXED a copy of the "Employee's Claim for Workers' Compensation Benefits," the "Employer's Report of Occupational Injury or Illness," off work orders, and any other pertinent medical or other documentation to Risk Management, please process both forms and the original documentation through your department following your normal procedures. Any subsequent off work orders and medical documentation should also be FAXED immediately upon receipt.

If you have any questions, call the Workers' Compensation Section of Risk Management at (909) 386-8655.

### DEPARTMENT OF INDUSTRIAL RELATIONS - DIVISION OF WORKERS' COMPENSATION

DEPARTMENT/DISTRICT: FAILURE TO PROVIDE THIS FORM TO AN INJURED/ILL EMPLOYEE WITHIN 24 HOURS OF RECEIPT OF REQUEST COULD RESULT IN SANCTIONS FROM THE STATE AGAINST THE COUNTY.

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete for "Employee" section and give the form to your employer. Keep the last copy until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Today's Date

### **EMPLOYEE:**

Titalino			
Dept. regularly employed — 1B	. Employee No. ————	1C. Date of Birth	
Home Address			
City	State	Zip	
Social Security No.	,		
Home Telephone No	Work Telephone No		
Date of Injury Time	of Injury	a.mp.m.	
Address/Place where injury happened			
Occupation5B. Date	e of Hire 5C. Supe	ervisor's Name	
Describe injury and part of body affected (i.e., cut strain, fraction)	ure, rash, part of body affected,	l, etc.)	
How did injury occur?			
Signature of Employee ———————————————————————————————————			
PLOYER: (Department/District) COMPLETE THIS	SECTION AND GIVE THE EM	IPLOYEE A COPY IMMEDIATELY AS A RE	CEIPT.
Name and address of employer (Group, Department and Divis	sion)		
Date employer first knew of injury			
Knowledge of injury/illness acquired from (employee. supervise)	sor. relative. coworker. etc.)		
Date claim form was provided to employee			
Date employer received claim form			
Name and address of insurance carrier or adjusting agency	RISK MANAGEMENT DIVISIO	ON, 222 West Hospitality Lane, Third Floor	
San Bernardino CA 92415-0016			
Sail Demarding CA 92415-0010			
Signature of Employer Representative			
	City	City State  Social Security No Work Telephone No  Home Telephone No Work Telephone No  Date of Injury Time of Injury  Address/Place where injury happened 5B. Date of Hire 5C. Sup  Describe injury and part of body affected (i.e., cut strain, fracture, rash, part of body affected	Social Security No

**DEPARTMENT/DISTRICT:** You are required to date this form and fax to Risk Management and provide a copy to employee, dependent or representative who filed claim within **one working day** of receipt of completed form from employee. If you fail to date stamp this form before returning to employee a \$100 penalty could be assessed against your department/district.

DISTRIBUTION: Original + 1 Dated Copy: To Risk Management, 222 West Hospitality Lane, Third Floor, San Bernardino CA 92415-0016, Phone (909) 386-8655, Fax (909) 386-8711 along with completed Employer's Report of Occupational Injury or Illness within 48 hours of receipt of report from employee, dependent or representative. Dated Copy: To employee named in #1 above. Dated Copy: To Department/District named in #8 above.

07-633-000 Rev. 1/94 SIGNING THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM NOR IS IT AN ADMISSION OF LIABILITY.

Forms/empl claim for wc benefits.doc

(THIS INFORMATION IS FOUND ON THE BACKSIDE OF THE EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS FORM)

### **WORKERS' COMPENSATION BENEFITS**

**MEDICAL CARE.** Your employer will arrange for medical care, and all costs are paid directly by your employer's insurance company, so you should never see a bill. All medical treatment to cure or relieve your condition will be provided without a deductible or dollar limit.

**PAYMENT FOR LOST WAGES.** If you're temporarily disabled by a job injury or illness, you'll receive tax-free income until your doctor says you are able to return to work. Temporary disability payments are two-thirds of your average weekly pay, up to a maximum set by state law. (Some employees are entitled to receive full salary in lieu of temporary disability payments.) Payments are not made for the first three days you are disabled unless you are hospitalized as an inpatient or unable to work for more than 14 days.

**REHABILITATION.** If the injury or illness prevents you from returning to the same job, you may qualify for vocational rehabilitation benefits, with all costs paid by your employer's insurance company.

**PAYMENT FOR PERMANENT DISABILITY.** If the injury or illness results in a permanent handicap, permanent disability payments will be necessary after recovery.

**DEATH BENEFITS.** If the injury results in death, a benefit will be paid to surviving dependents.

If you need assistance completing this form or have questions regarding your benefits, please contact the State Office of Benefit Assistance and Enforcement by calling toll free **1-800-736-7401**. This service is provided to you at no cost. You also have the right to consult an attorney.

Forms/workers' comp benefits..doc

### MEDICAL SERVICE ORDER

Form No. 16-13212-000 Rev. 11/93

If an employee is injured on the job or develops an occupational illness that needs medical care or treatment by a physician, clinic or hospital, a copy of the Medical Service Order is to be sent with the employee when the supervisor takes the employee to the doctor. This form is necessary to provide the correct billing address for the physician or medical facility and to ensure that all State-required reports are sent to the correct address. These forms are to be ordered from Central Stores.

After providing the needed medical treatment to the injured employee the doctor should complete the bottom section and give the original (white) copy and the second page (canary color) of the Medical Service Order back to the employee. The employee should then take the medical service order back to their supervisor as this has the injured employee's medical status on it. The supervisor retains a copy of the form and faxes, then mails the original, top copy to Risk Management (*The only exception to this procedure would be if it is a HSS employee who is injured, the department supervisor, or department designee should fax, and then mail all pertinent documents to HSS Personnel for handling and forwarding to Risk Management)*.

### There are instances when giving an employee a medical service order to obtain treatment may not be appropriate. Some examples of this are:

- 1. When an employee delays reporting an injury (This should be evaluated by Risk Management personnel to determine if a medical service order should be given ).
- 2. When an employee has a "continuous trauma" type of injury such as hand, wrist, arm, neck, or back pain that develops over a period of time (weeks, months or years).
- 3. When an employee becomes ill on the job, but there is no particular part of their job or work environment that seemed to directly cause the illness on the day the employee claims the injury occurred.
- 4. Claims of Emotional Stress or Emotional Trauma unless there is a specific traumatic incident that happens on a particular day (legal disciplinary actions taken against an employee by an employer that may effect the employee's emotional state are not considered a work related injury).

If an employee claims one of these types of injuries/illnesses DO NOT SEND THEM TO A DOCTOR OR MEDICAL FACILITY WITH A MEDICAL SERVICE ORDER. You should still provide the employee or their representative with the "Employee's Claim for Workers' Compensation Benefits" and complete the "Employer's Report of Occupational Injury or Illness" as you normally would. You would then submit the forms and any related paperwork the employee provides to you to Risk Management (or HSS Administration if an HSS employee) via fax, and then the originals through your department channels as you would any other claim. Risk Management will review the claim and may need to advise the employee of a delay in provision of benefits until a decision can be made as to whether the condition is work related. State law allows a period of up to ninety (90) days, and sometimes more in order to collect all the facts surrounding the injury or illness. If you are not sure whether to give an employee a Medical Service Order, please call Risk Management at (909) 386-8655 for assistance. If it is "after hours", or on the weekend and the injury or illness falls in to one of the above categories, the employee should referred to their regular health care provider, using their private health insurance and retaining all receipts for payment related to the injury. Risk Management will then review the employee's claim and respond with a decision as to whether it will be an "accepted claim". If the claim is accepted, Risk Management can reimburse the employee if the documentation of costs can be verified.

### HOW TO FILL OUT THE MEDICAL SERVICE ORDER

Form No. 16-13212-000 Rev. 11/93

- 1. Insert the <u>full name and address of the physician or medical facility chosen by the employee from the Physician's Referral List</u> on the first line of this form. If the employee has predesignated their own personal physician by submitting a request, in writing, to Risk Management <u>prior to the injury</u>, they may choose to use this physician instead. **Do not give an injured employee a medical service order that does not have the physician's or medical facility's name and address (at least the city) filled in. This is authorization for the doctor or facility to bill the County for their services.**
- 2. Insert the employee's full name, and middle initial, if any, on the second line.
- 3. Insert the date of the injury or illness and the exact time the accident occurred or the illness developed (if this information is known).
- 4. Insert the complete, official name of your department and group in the "Department <u>(blank)</u>." If you are working in a branch office, also include the location.
- 5. The signature of the supervisor or the department designee sending the employee to the doctor or medical facility here in "Signed By (blank)." If the signature is not clearly legible, please print the name to side or under the signature so that the referring person can be identified.
- 6. Insert the date the employee is being sent for medical care in the "Date (blank)."
- 7. The title (Job Classification) of the supervisor or department designee signing the Medical Service Order is inserted in the "Title (blank)."

NOTE: Definitions of physical activities are printed on back of form.

### County of San Bernardino --- Risk Management Division

### MEDICAL SERVICE ORDER FOR OCCUPATIONAL INJURIES OR ILLNESSES

DOCTOR	R				ADDRESS		
	•	Name of Employee		was injured on		at	Time
Doctor's o Work <b>Bernard</b>	our en s First l «" orde l <b>ino, C</b>	mployment. Pleas Report of Occupat ers to: <b>RISK M</b>	se give the no ional Injury of ANAGEMENT the faxing the	r illness," all repor <b>DIVISION, 222</b> completed Med	ts, bills, "Modif 2 West Hosp lical Service C	itely, then complete ied Work", "Off Work itality Lane, Third Order and Status Ro	and send the k" and "Return d Floor, San
DEPARTI	MENT	***************************************			_ Signed By _	Nam	e of Authorizer
Date	· · · · · · · · · · · · · · · · · · ·		Time	***************************************	Title		
e d	mploy epartn	ees injured on the nent after faxing	ne job. Pleas or mailing a	se return the ori	ginal of this fo anagement.	dified Duty Progra orm with the emplo	
			•		•	INJURY	
MPLOY	EE -	,		_ DEPARTMENT		DATE _	
his emp	ployee	is under our care	with a diagno	sis of ———			
. 🗆	May re	eturn to REGULAR \	WORK on	Date		at	Time
. 🗆		eturn to <b>MODIFIED \</b> the following restric				at	Time
		☐ Standing ☐ (Specify length of t☐ Restricted from☐ No hazardous☐ Not permitted t	Turning Twisting Sitting Sitting ime, if any, for Ilifting in exce machinery ope o operate moto noxious dusts	limitations:ss ofsration or vehicle (overs, fumes, or chemic	cess of pounds —_hours daily)	☐ Climbing ☐ Keyboard Use _ % of work shift —— _ % of work shift	— hours)
	D. a. And	☐ No tasks required No rotating or reduction ☐ Restricted to w	ring depth or conight shifts or conight shifts	olor perception or p hours per shift or 2	4-hour period.		
3. 📙		iction is temporary	юг	uays	weeks	months	
1	Other	restrictions					
RETURN APPOINT		Date			Physi	ician's Signature	

DISTRIBUTION: Original – Risk Management Second Copy – Employee's Department Third Copy – Physician's Records Fourth Copy – Department's Temporary Receipt

16-13212-000 Rev. 11/93 rmdforms/medsvcordr.doc

### **DEFINITIONS OF PHYSICAL ACTIVITIES**

- 1. SITTING: **Remaining in the normal seated position**. To rest weight on buttocks and back of thighs with legs bent at knees.
- 2. STANDING: Remaining on one's feet in an upright position at a workstation without moving about. To maintain entire body in erect posture without change in location.
- 3. WALKING: Moving about on foot. To move entire body for some distance using heel-toe gait.
- 4. LIFTING: Raising or lowering an object from one level to another (includes upward pulling). To exert physical strength necessary to move objects from one level to another.
- 5. CARRYING: Transporting an object, usually holding it in the hands or arms, or on the shoulder. While walking, to hold or rest weight directly on hands, arms, shoulders, back,
- 6. PUSHING: Exerting force upon an object so that the object moves toward the force (includes slapping, striking, kicking, and treadle actions). To exert force upon or against an object in order to move it away.
- 7. PULLING: Exerting force upon an object so that the object moves toward the force (includes jerking). To draw or haul toward oneself, in a particular direction, or into a particular position.
- 8. CLIMBING: Ascending or descending ladders, stairs, scaffoldings, ramps, poles, and the like, using feet and legs and/or hands and arms. Body agility is emphasized. This factor is important if the amount and kind of climbing required exceeds that required for ordinary locomotion. To ascend or descend ladders, scaffolding, stairs, poles, inclined surfaces.
- 9. BALANCING: Maintaining body equilibrium to prevent falling when walking, standing, crouching or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats. This factor is important if the amount and kind of balancing exceeds that needed for ordinary locomotion and maintenance of body equilibrium. To maintain body equilibrium on narrow or inclined surfaces.
- 10. KNEELING: **Bending legs at knees to come to rest on knee of knees**. To position body with one or both knees fully flexed and resting on level surface.
- 11. CROUCHING: **Bending body downward and forward by bending legs and spine**. To flex forward at waist with full flexion of knees.
- 12: CRAWLING: **Moving about on hands and knees or hands and feet**. To move entire body along a surface with hip and knee flexion and arm extension/flexion.
- 13. REACHING: Extending hand(s) and arm(s) in any direction. To position arms with full extension of elbows.
- 14. HANDLING/GRASPING: Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand.
- 15. MANUAL DEXTERITY: Makes skillful, coordinated movements of fingers and hands to feet, grasp, place, move or assemble objects.
- 16. BENDING: To flex upper trunk forward (knees extended, standing; knees flexed, sitting)
- 17. SQUATTING: To flex knees and hips, the buttocks being lowered to the level of the heels.
- 18. TWISTING: To rotate entire body to a change in direction.
- 19. TURNING: To rotate upper trunk to right or left from neutral while sitting or standing.
- 20. STOOPING: Bending body downward and forward by bending spine at the waist. This factor is important if it occurs to a considerable degree and requires full use of the lower extremities and back muscles. To flex upper trunk forward at waist and partial flexion of knees.
- 21. HEARING: Perceiving the nature of sounds.

NOTE: Descriptions highlighted in bold were excerpted from the "Dictionary of Occupational Titles, 4<sup>th</sup> Edition Supplement 1986".

medsvcrdef/rmdfrms/

### **EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

Form No. 15-14248-000 Rev. 6/98 (State Form No. 5020)

\*\*\* Not To Be Used To Report Exposure To Blood Or Exposure To Body Fluids Or Communicable Disease \*\*\*

May be used only if this exposure results in the employee contracting an illness or disease from such and exposure. Please refer to the instructions for completion of the "Bloodborne Pathogen & Tuberculosis Exposure Report" on page (176) of this manual.

+++

The "Employer's Report of Occupational Injury or Illness" is always to be completed when an employee files a Workers' Compensation claim (it should not be completed just to document an incident. In this case, please refer to the instructions for the "First Aid Record" on page (142) of this manual.

**★**This form is to be completed by the employee's supervisor or other department designee. <u>It should</u> never be completed by the injured employee.

<u>Please read all instructions in each section carefully so that the correct and most accurate information is recorded on the form.</u> This will help to expedite processing of the claim for your employee and assist Risk Management personnel in providing all benefits to which the employee may be entitled.

If you need to include any additional information that will not fit on the form, or other information to clarify that given on the form, please attach a separate sheet of paper to the Employer's Report.

For all Departments other than HSS (which is to FAX all paperwork to HSS Personnel), the "Employer's Report of Occupational Injury or Illness" should be FAXED to Risk Management immediately upon completion, or at least within 48 hours along with the "Employee's Claim for Workers' Compensation Benefits" form. Risk Management's FAX numbers are (909) 386-8711 or (909) 386-8670. After you have FAXED a copy of the "Employer's Report of Occupational Injury or Illness," the (Employee's Claim for Workers' Compensation Benefits" form, and any other pertinent documents (i.e., off work orders, return to work order, or other medical documentation from the treating physician), please process both forms and the original documentation through your department following your normal procedures. Any subsequent off work orders and medical documentation should be FAXED immediately upon receipt.

IF YOU HAVE ANY QUESTIONS ON COMPLETING THIS FORM, OR ANY OF THE PROCEDURES IN THE CLAIMS PROCESS, PLEASE CONTACT RISK MANAGEMENT AT (909) 386-8655

Step by step instructions are included on the following page to assist you in completing this form

### HOW TO FILL OUT EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form No. 15-14248-000 Rev. 6/98 (State Form No. 5020)

- Leave blank.\*
- Complete (Use Section or Division's correct Organization Code. This five digit number can be obtained from your department payroll clerk).
- 2. Leave blank.\*
- 2b Complete (Obtain this six digit coding from Fund & Accounting Manual or your department payroll clerk--may be alpha, or numerical, or both).
- 3. Do not complete.
- 3a. Complete (also known as "building number." This four digit number identifies the job site of the injured employee. All County owned or leased buildings have their own designated code. This information can be obtained from the County "Intranet" System. It is also published in the "Schedule of Buildings Owned by San Bernardino County or Rented/Leased by San Bernardino County."
- 4. Leave blank.\*
- 5. Leave blank.\*
- 6. Leave blank.\*
- Complete, full name of employee and employee number (if an employee has recently married, make sure to include maiden name in parentheses).
- 8. Complete.
- 9. Complete.
- Complete (please list both the mailing and home address of the employee, if different, including zip code).
- 10a. Work phone number with area code.
- 11. X male or female.
- 12. Complete (employee's regular job title).
- 12a. Complete official department and district that employee works for (i.e., Sheriff/Patrol Division, Clerk of the Board of Supervisors, Public Health, General Services Group/Facilities Management, etc.).
- 13. Complete (date of hire with County--also, please indicate here or elsewhere on form if date of hire with this department is different than County hire date)
- Complete (if employee is on other than a 5-day per week, Mon-Fri schedule, please indicate particulars of their schedule elsewhere on form or by attachment).
- 14a. X whether employee is permanent, part time, temporary or volunteer (this is very important because of different benefits).
- 14b. Do not complete.
- 15. Weekly wages (must be correct and up-to-date to ensure correct benefits).
- 16. Complete.
- 17. Complete.
- 18. Complete (exact time of day the incident occurred or the illness developed).
- 19. Complete.

- 20. Complete.
- 21. Complete.
- 21a. Complete.
- 22. Complete (if applicable).
- 23. Complete (if applicable).
- 24. Complete (if applicable).
- 25. Complete.
- 26. Complete.
- Complete (date employer/supervisor was advised by employee or other source of employee's injury or illness).
- 28. Complete (date employee or their representative was given or mailed by "US Postal Service, First Class Mail" the employee claim form).
- 29. Complete as fully as possible.
- 30. Exact location of the injury, includes parking lots, grounds (street address, city).
- 30a. County where injured (and State if other than Calif.).
- 30b. Complete.
- 31. Complete.
- 32. Complete (if other employees injured, please indicate names elsewhere on form or by attachment).
- 33. Complete (with exact name of the machine, tool, object, chemical, etc. that the employee was using or came in contact with when injured. If a chemical or poison was involved and the exact name is not available, the trade name or any other information to identify it should be retained and reported here. The name of the Vendor is also desirable).
- 34. Complete with as much detail as possible.
- 35. Complete as fully as possible (save any tools, equipment, etc., for future inspection and investigation).
- 36. Complete (this is the name of the physician that first examines the employee for the injury or illness. If the employee sees other physicians, please include on a supplementary attached sheet. Include the name and address of doctor, hospital, or medical clinic where employee was treated for the injury or illness. If no medical treatment when form is completed, please indicate here).
- Complete if the employee is hospitalized (be sure to include the name and address of the hospital here to ensure that the correct benefits are paid).
- 38. Complete if applicable (please include full names of witnesses and phone numbers, if available).
- 39. Complete.

### **SIGNATURE SECTION:**

Completed by: Name of person completing the form (cannot be the injured employee), their Signature, Title and Date form completed.

Supervisor Signature \* Department Head Signature \* Assistant Administrative Officer Signature \* Date signed by Supervisor

<sup>\*</sup> Already filled out for you.

State of California  EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS  PLEASE COMPLETE IN QUINTUPICATE (TYPE IF POSSIBLE) This report is to be completed by the Supervisor, NOT the employee. Retain one copy for your files and mail the original and two copies to: COUNTY OF SAN BERNARDINO Risk Management Division/Human Resources 222 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0016							FAX UF	(909) 38 PON COMPLETI (909) 38 or (909) 38	ON TO 6-86711 6-8670	OSHA Case NO.			
k ma	nowin terial	erson who make or ca gly false or fraudulent representation for the rorkers' compensation guilty of a fe	t material state purpose of ob a benefits or pa	ment or taining or	which results subsequently knowledge a	s in lost time y dies as a r in amended	beyond the esult of a pre report indica	date of viously ting de	f the incid y reported ath. In a	dent OR red d injury or i addition, ev	e days of knowledge quires medical treat Ilness, the employe ery serious injury/illr ne California Divisio	ment first aid. It r must file within ness or death m	five days of ust be reported
E	1.	FIRM NAME	NTY OF SAN B	ERNARDINO .		NAGEMEN	IT		1A. D	EPT. ORG	CODE		DO NOT USE THIS COLUMN
M	2.	MAILING ADDRESS 222 WEST HOSPITA							2A. D	EPT. FUN	D & SUB FUND		Case No.
P L	2.	LOCATION, if differer	nt from mailing a	address (Numb	per and Street,	City, ZIP)	13-0010		3A. L	OCATION	CODE		Ownership
O Y	4.	NATURE OF BUSINE	ESS, e.g., painti	ng contractor,	wholesale, gro	ocer, sawmil	l, hotel, etc.	5.	STAT NO.	E UNEMPL	OYMENT INSURAN	CE ACCT.	Industry
Ē	6.	TYPE OF EMPLOYE	R								N/A		Occupation
R		PRIVATE S	STATE C				ERNMENT-			DA-	TE OF BIRTH		Sex
Ε	7.				8.	SOCIAL SE	CURITY NU	WBER					
М	10.	HOME ADDRESS (N									HONE NUMBER	work	Age
P L	11.	SEX MALE   FEMALE	n	DEPARTMEN		itle NO ii	nitials, abbre	viation	s or	13. D/	ATE OF HIRE		Daily Hours
O Y E	14.	EMPLOYEE USUAL hrs days per day per wee ———————————————————————————————————	LY WORKS total v	weekly	14A. ST time of in regul	njury) ar me □ par	eck applicabl t-time ☐ ter				nder what class cod ere wages assigned		Days per week
	15.	GROSS WAGES/SA \$	LARY PER				MENTS NOT eals, lodging,					ÆS 🗌 NO	Weekly Hours
	17.	DATE OF INJURY O	R ONSET OF		INJURY /ILLN URRED A.M.	P.M.	wo	RK A.M.		.M.	DATE (	OYEE DIED, OF DEATH DDYY	Weekly Wages
I N	21. 21A	UNABLE TO WORK DAY AFTER DATE (	OF INJURY?	YES NO	wo	TE LAST DRKED	23. DAT WO	RK	TURNED			OFF WORK THIS BOX	County
U R	25.	PAID FULL WAGES FOR DAY OF INJUR	Y? CO	LARY BEING NTINUED?	KN	TE OF EMP OWLEDGE JURY/ILLNE MM/DD	NOTICE OF		2		E EMPLOYEE WAS EMPLOYEE CLAIN MM	// FORM	Nature of Injury
Y	29.	SPECIFIC INJURY/II tendonitis of left elbo	LNESS AND F	PART OF BOD	Y AFFECTED			, (If av	ailable, e	e.g.,. secon	d degree burns on	right arm,	Part of body
O R	30.	LOCATION WHERE OCCURRED (Numb			30A. CC	DUNTY		30B.		MPLOYER'S	S PREMISES? O		Source
. <b>.</b> I	31.	DEPARTMENT WHE shipping department,		EXPOSURE	OCCURRED,	e.g.,			RKERS NO	INJURED/	ILL IN THIS EVENT	Γ	Event
L	33.	EQUIPMENT, MATE welding torch, farm tr		EMICALS THE	EMPLOYEE	WAS USIN	IG WHEN E\	ENT (	OR EXP	OSURE O	CCURRED, e.g., ac	etylene,	Soc. Source
N	34.	SPECIFIC ACTIVITY loading boxed onto the		EE WAS PERI	FORMING WH	HEN EVENT	OR EXPOS	URE (	OCCURF	RED, E.G.,.	welding seams of	metal forms,	Extent of Injury
E S S	35.	HOW INJURY/ILLNES e.g., worker stepped ba											
	36.	NAME AND ADDRES	S OF TREATIN	IG PHYSICIAN	(Number and	Street, City	/ Zip)		, M.		36A. PH	/SICIAN'S PHO	NE NUMBER
	37.	IF HOSPITALIZED A	S AN INPATIEN	NT, NAME ANI	D ADDRESS (	OF HOSPIT	AL, (Number	and S	street, Cit	ty, ZIP)			
	38. 39.	WITNESS  CORRECTIVE ACTION	ON TAKEN TO	PREVENT RE	CURRENCE					WWW.			
Com	pleted	by (type or print)		Signature			Title					Date	
	ervisor	-		Dept. Head			Assist		lministra	ative		Date	50 V

ė.			

### MODIFIED DUTY PROGRAM (FOR EMPLOYEES WITH WORK RELATED INJURIES OR ILLNESSES)

The Modified Duty Program is a mandatory, County-wide program designed to return employees to the workplace doing tasks they are medically able to perform as soon as possible and until they are able to return to full duty. The County will accommodate an employee's medical restrictions so that injured workers will continue to earn regular salary and benefits for time worked. Employees unable to return to work in any capacity will be provided mandated benefits under California Workers' Compensation Law per the State Labor Code.

The County Modified Duty Coordinator (an employee of the Risk Management Division of Human Resources) assists the employee's department in coordinating the return to work of the employee with the assistance of the employee's treating doctor, the County Center for Employee Health & Wellness Doctor or Nurse, the Department's Modified Duty Coordinator, the injured employee's supervisor, and the injured employee.

When an employee's supervisor learns of a job-related injury or illness, they should refer to the "Reporting Procedures" section of this manual for specific requirements and forms which will need to be completed.

Once the employee has seen a doctor, they should either have the "Medical Service Order" which has been completed, or other paperwork from the doctor that gives information regarding the patient's medical status (any medical status form or report that is signed by anyone other than a doctor is not valid--if it is signed by a physician's assistant or a nurse practitioner, it will not be accepted until the doctor's signature is obtained. If this delays the employee returning to work, the additional time off work may not be covered under workers' comp. benefits). This form, or the doctor's paperwork should be taken back to the department by the employee and reviewed by the supervisor or other department designee.

If the employee does not return to his/her department with the medical documentation because he/she is unable to due to the injury, they should call the supervisor or other person "in charge" to advise them of this situation. Arrangements will then need to be made for the department or Risk Management to obtain the needed documentation. It is the employee's responsibility to keep the department apprised of their medical condition initially, and thereafter with any changes in the status. The injured employee should contact their supervisor or other person designated by the department at least once a week. Failure to provide ongoing medical documentation could result in delay or denial of continuing benefits.

The medical documentation should include one of the following statuses:

- 1. The employee is released by the treating doctor to return to work immediately, or to return to work the following day, or next shift, whichever is appropriate to the employee's work schedule.
- 2. The employee is taken off work by the doctor.
- 3. The employee is released to modified duties--there should be a clear indication of what the medical restrictions are to be.
- 4. If you are unsure of the status of a claim or anticipate potential problems with a claim, call Risk Management at (909) 386-8655 to speak to a Claims Adjuster, Claims Assistant or call the County Modified Duty Coordinator at (909) 388-4688.
  - → Do not implement modified duty assignments for employees with "stress related" or other emotional injuries/illnesses unless you are advised to do so by Risk Management personnel.

If the paperwork indicates that the status is either "off work" or "modified duty" the supervisor should then contact the department Modified Duty Coordinator to advise them of the employee's medical status. If the department Modified Duty Coordinator is unavailable, the supervisor should contact Risk Management to advise either the County Modified Duty Coordinator or the Claims Adjuster or Claims Assistant who will be handling the workers' comp. claim. A copy of the paperwork should be faxed to them at (909) 386-8711.

### Employee's who are:

- a) Taken off work due to an occupational injury and are being released back to work,
- b) Are being sent back to work with medical restrictions by the treating doctor,
- c) Are being released back to full duties after being on modified duties, or
- d) Have a change in their medical restrictions by the treating doctor.

### Must be seen at The Center For Employee Health & Wellness before returning to work.

The supervisor or other department designee makes the appointment for the employee. Occasionally, employees who are in very remote areas of the County may be released by the County Employee Health Doctor or Nurse by a phone interview--if this is the case, the supervisor should make these arrangements with the Center for Employee Health & Wellness Office, (909) 386-5150.

The employee will need to have been released to full or modified duty by the treating doctor, and obtain a written release from the doctor, before they are seen at the Center for Employee Health & Wellness for review of the doctor's return to work release. If possible, the employee should be scheduled for the Center for Employee Health & Wellness appointment at least one working day prior to the treating doctor's date of release so that the employee may return to work on the date specified by the treating doctor (weekends, holidays, and Employee Health & Wellness staffing needs may, in some instances, delay the date of the appointment, but this is usually not a problem).

The Supervisor, with assistance from the department Modified Duty Coordinator and if needed, the Department Human Resources Officer, will determine modified duty assignments for the employee when he/she returns to work. This return to work date must occur as soon as possible after the employee is released by the treating doctor. If there is no modified duty available within the employee's department, the County Modified Duty Coordinator will work with the Department Modified Duty Coordinator to place the employee in another County Department. It is important that all possibilities of placing the employee in their own department are explored as the employee's department continues paying the employee's regular salary and benefits for time worked.

Modified duty assignments will end upon release of the employee to full duty, or if modified duty assignments are no longer available, or if the employee's medical restrictions are determined to be of a permanent nature.

If an employee fails to show for scheduled assignments, interviews, or fails to follow the medical restrictions the doctor has imposed contact your Department Modified Duty Coordinator immediately. Workers' Compensation benefits will be terminated for employees who refuse to comply with modified duty assignments.

Also contact your department coordinator if the employee is missing scheduled doctor's appointments, physical therapy appointments, etc. If you are unsure what to do in a given situation, be sure to contact your Department Coordinator or Risk Management for guidance in handling the situation.

If your Department has other requirements or responsibilities regarding modified duty assignments for employee's, you should continue to adhere to the policy as set forth by your Department.

### HOW TO FILL OUT VEHICLE ACCIDENT REPORT FORM

Form No. 15-5705-000 Rev 1/94

- Before an accident happens, fill in your department's telephone number and insert the Vehicle Accident Report Form in your vehicle's glove compartment. Motor Pool vehicles should have these already in the glove compartment. Check before leaving. Forms are available at Central Stores.
- 2. When an accident has happened to you, or you think you may be named as a party to an accident (even if the vehicle only touched you or swerved from your path and collided with others), park the car safely, immediately.
- 3. Take out the yellow Vehicle Accident Report and read Sections 1 through 6 carefully. Follow the instructions in these sections. Serious property damage is any damage over \$2,500 to either party. Bodily injury can be as minor as a sore neck or arm.
- 4. The sections to be completed are mostly self-explanatory. It will help our investigator if you obtain the officer's name that took the initial accident report, and when possible, the accident report number (also known as a daily report (D.R.) or traffic accident (T.A.) number). Ask the traffic officer for the names of other parties if there are injuries. Complete <u>all</u> blanks.
- 5. Study the accident diagram and block out the types of intersections that don't apply to your accident. If this is not an intersection accident, draw curb lines over the intersection's cross streets and treat the diagram as if it showed a view of a straight street.
- 6. If serious injury occurs to a County employee or member of the public, call Risk Management Division at (909) 386-8631 as soon as possible. On weekends, call Comm Center at (909) 356-3811. They have the telephone number for our on-call staff. Follow any departmental directives you may have on serious injuries or accidents for further reporting.
- 7. This card is then given immediately to the employee's immediate supervisor so it can accompany the Incident Report form when sent to Risk Management Division/Human Resources.

### THE INJURED PERSON

Names and Address	Age	් ට්	Check Which (x)		
1		<ul><li>☐ Pedestrian</li><li>☐ Driver</li><li>☐ Passenger in Vehicle</li></ul>	☐ Male ☐ Female Vehicle		Killed Injured
2		☐ Pedestrian ☐ Mal ☐ Driver ☐ Fen ☐ Passenger in Vehicle	☐ Male ☐ Female Vehicle		Killed Injured
3		☐ Pedestrian ☐ Mal ☐ Driver ☐ Fer ☐ Passenger in Vehicle	☐ Male ☐ Female Vehicle		Killed Injured
Given First Aid by					
Taken to		-	(Hospital, Clinic)	tal,	Clinic)
What?					
158					
DAMAGE TO OTHER'S PROPERTY	IHER'S PI	ROPERTY			
Address		Phone:			
Kind of property and how damaged					
Estimated cost of repairs \$					
•	, Yr.	License No.			
Where may it be seen?					
Is it covered by insurance?   Yes   No	Insurance Co. Policy #	.e Co.			
I declare, under penalty of perjury, the above is true and correct to the best of my knowledge.	is true and	correct to the	e best of my kr	owle	adge.
Signature of County Driver	).		10000	,	dent
NOTE: If no police or traffic officer was able to respond to your request, report incident	ble to resp	ond to your re	duest, repur	2 = 1	מבנונ

County of San Bernardino

# Vehicle Accident Report

## INSTRUCTIONS TO DRIVERS

3. If anyone is seriously injured, call a

- 1. In case of accident, (no matter how slight), STOP at once and investigate. Write all facts of accident on this form.
- 2. Make no admission of liability and assume no responsibility for accident to anyone. The law requires that you need give only the following items of information.

Name and address of driver.

Name and address of owner of vehicle.

License plate number of vehicle.
If requested, exhibit your operator's or chauffer's license.
(Calif. Vehicle Code, Section 20003)

doctor and render reasonable assistance. Do not authorize medical or surgical relief except as is imperative at the time of the accident. If accident Is serious (results in bodily injury or serious property damages) call Traffic Emergency 911 and telephone your immediate superior or department.

ALSO call Risk Management Division Phone: 386-8631

- 5. DO NOT ATTEMPT TO ADJUST THIS ACCIDENT.
  - 6. ALWAYS call a Law Enforcement Officer to the scene.

Immediate Supervisor.

Department/Group

Name of your

Your Name	Work Phone #
If you are not the County Driver, who was?	
County Equipment Number	Vehicle License Number
	ModelYr
Name of Other Driver	Phone #Address
License Number of Other Vehicle	Operator's License Number, Other Driver
Name and Address of Owner	•
Name of Police Officer	☐ Sheriff ☐ CHP ☐ City Police

NOTF. This form is for field use at the scene of the accident. Those return to vour office.

to local police department within 24 hours via a Counter Report.

Complete the following	ng diagram showing direction and	positions of automobiles or property involved, de	signating clearly point of contact.  Indicate points of compass - N.E.S.W.
		7//	1
			•
		1/1/	
INSTRUCTIONS:	GIVE STREET NA	MES DIRECTIONS AND LOCATIONS OF OR	5070 100/01/10
	ehicle and show direction of trave	MES, DIRECTIONS, AND LOCATIONS OF OBJ	ECTS INVOLVED
	o show path of each vehicle befor	e accident. 1 dotted line after ac	cident ·····
	cle or bicycle by	(4) Show pedestrian by	(5) Show railroad by
	IPLETE NAMES AND ADDRESS		Show County vehicle as number 1
- Cale Will	idases of Fersons Fiesent	Address	Vehicle License No. Phone
			☐ Business
			☐ Home ☐ Business
			☐ Home
NOTE: If	unable to get names of witnesses	, ALWAYS get the license number of those driver	Business Business sthat you believe witnessed the accident.
Σ.S.			
A G <b>E</b> E			
		nale la	
		Minors Fem.	
		\\ \	
. Hour_	9 9 9		
	Other Vehicle. Other Other Vehicle.	Male Male	o N □
<u> </u>	3		
DEN Y	Idres		☐ Yes
CCID.	et Ac	d de de	
THE ACCIDENT	(Street Address)	Adults Female Female Charge	Seat belts used?
Ė		dult dult fee fee	helts
	- j6		Seat
<u> </u>	goin		
Month	(OU cle _	Male Male Y: Y:	
	City, town or area  What direction were YOU going?  What side of street?  Speed of County vehicle  Weather conditions		Seat belts installed.
Date of accident:	City, town or area	No. of occupants of County vehicle No. of occupants of other vehicle Were YOU cited?  Was OTHER driver of Describe accident furth	
Date of accident:	wn oll wn oll ectic	No. of occupants County vehicle No. of occupants other vehicle Were YOU cited? Was OTHER driv Describe accident	
ofe	t dir t sid t sid	of o of	Seat
Date	City Wha Wha Spee	No. Court No. Other Mass Was Desc	

### **INCIDENT REPORT**

Form No. 15-13866-000 Rev. 1/94

The instructions for completing are on the reverse side of the form.

This is a generic form used for all injuries and accidents involving members of the public, all vehicle accidents involving County/District vehicles, and all damage, theft, destruction or disappearance of County property, money or securities.

Police reports must be obtained for all money losses, vandalism or malicious mischief.

### Instructions for Completion of COUNTY OF SAN BERNARDINO INCIDENT REPORT

#### for County Vehicle Accidents and General Liability Property Damage

- 1. Full name of County driver or reporting employee
- 2. County employee's home address
- 3. County employee's home phone
- 4. County employee's department
- 5. County Department/District Department and Coding
- 6. Address of employee's department
- 6A. Complete
- 7. Complete
- 8. Complete
- 9. Complete
- 10. Indicate if you have had other accidents
- 11. Complete
- 12. Employee's driver's license number
- 13. Complete
- (14-23. Complete only if incident involves a County vehicle)
- 14. Indicate 5 digit County vehicle number.
- 15. Give license plate number of vehicle
- 16. Complete
- 17. Complete
- 18. Complete
- 19. Complete
- 20. Complete
- 21. Complete
- 22. Acquire estimates of damage from Motor Pool
- 23. Complete
- 24. IMPORTANT! Give exact date of incident
- 25. Complete
- 26. Complete
- 27. Complete
- 28. Indicate location of enforcement agency taking report. NOTE: All accidents must be reported to Law Enforcement with jurisdiction.

- 29. Give exact location
- 29A. Nearest cross street to accident
- 30. Complete
- 31. Complete
- 32. Indicate full name of other party if applicable
- 33. Complete
- 34. Complete
- 35. Complete
- 36. If owner is other than No. 32, indicate full name
- 37. Complete
- 38. Complete
- 39. Describe property fully.
- 40. Is property insured?
- 41. Complete
- 42. Describe type of damage if any.
- 43. Give your opinion of cost to repair damage.
- 44. Complete
- 45. Full name, address and phone number of injured.
- 46. Complete
- 47. Complete
- 48. Check block to show if injured was in County vehicle, other vehicle or pedestrian
- 49. Full name, address and phone number of injured.
- 50. Complete
- 51. Complete
- 52. Check block to show if injured was in County vehicle, other vehicle or pedestrian.
- 53. Full name, address and phone number of witness
- 54. Check block to show if witness was in County vehicle, other vehicle or pedestrian.
- 55. Full name, address and phone number of witness
- 56. Check block to show if witness was in County vehicle, other vehicle or pedestrian.

**NOTE**: Report is **never** to be completed by employee involved in Automobile Accident. Form must be completed and signed before submitted.

### County of San Bernardino INCIDENT REPORT

	CONFIDENTIAL	INCI	DENT REPORT					
R.M.D.	age 2 for instruction) PLEASE TYPE COUNTY OF SAN BERNARDINO 222 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0016 (909) 386-8631	<ul><li>Acquire super</li><li>Acquire sign</li><li>Submit with</li></ul>	ems No. 1 through ervisor's comment latures of Departm yellow Accident R It within 24 hour of	s and signature ent and Group eport card to R	Head	Other Acci Disposition SARB NO.:	n: First and S Ri Thi	econd copy to sk Managemen rd copy to Dept
	Driver (or Reporting Employee for Non-	Auto) 2. Ho	me Address	2	?a. Social Se	curity #	3. H	Home Phone
COUNTY EMPLOYEE	4. Department 5. Dept. No	6. Ad	dress of Departme	nt 6	A. Contract	city, if applica	able 7. [	Dept. Phone
CO		D. Prior Accidents  Yes N	o 11. Employe	e's Job Title	12. Driv	er's License I	No. 13.	Work Phone
NTY CLE	14. County Vehicle No. 15. Plate No.	16. Motor Poo	ol Car? 1	7. Color	18. Yea	ır 1	9. Make	20. Model
COUNTY	21.  Minor  Major  Major  Damaged Part		Repair Estimate fr Motor Pool	om 2	23. Where ca	an car be see	en? When	?
N OF	24. Date of Incident 25. Time	A.M. P.M.	er 27. Condit	on of Road		vehicle accide	IP  Police ents must be r	
ESCRIPTIC	<ol> <li>Location of Loss (Street address, city,</li> <li>Nearest Cross Street</li> </ol>	state)	30. County Vehicle: Est. Speed — Other vehicle:	MPH _		n Traffic  in Traffic	Moving Moving	
SUPERVISOR'S DESCRIPTION OF INDIDENT	31. Supervisor's Description of Incident:		Est. Speed	MPH				
	32. Other Party's Name	33.	Address		37. Driver	's License No	o. 35. Ph	one
ARTY	36. Owner	37.	Address		1		36. P	none
OTHER PARTY	39. Describe Property (If car, make, year, plate	insu	red? 🗌 No		Insurance Company an		and Policy No.	
Б	42. Describe Damage	43. Repa	air Estimate	44. Where c be seen?	an property	County Vehicle	Other Vehicle	Pedestrian
RIES	45. Name Address I	Phone No 46.		nt of Injury ∕linor	· □ Death	48.		
INJUR	49. Name Address I	Phone No. 50.		nt of Injury ∕linor  ☐ Major	· ☐ Death	52.		
ESS	53. Name Add	ress	Phone No.			54.		
WITNESS	55. Name Add	ress	Phone No.			56.		
VIEW	Do you feel County driver could have a     Why?	voided this acciden	t?	□ No				
SUPERVISOR'S REVIEW	Hours employee worked prior to Incident?		alo2 🗆 Vo- 🗀	No.	1 Was safe-	hi oquinmasi	uood2 🗔 V	no 🏳 Ni-
SUPERVI	Were there any known mechanical defer If yes, list:     What habits should County drivers devertible.			No 3/		ty equipment te deficiencie	used?	INO
		_						
·····	Supervisor's Name – Typed/Printed	Depar	rtment Head's Name -	Typed/Printed			nty Administrative (if applicable)	Officer

confidential and is to be used only for accident analysis. 15-13866-000 Rev. 1/00 forms/incidntrpt.doc

#### **CLAIMS AGAINST THE COUNTY**

Form No. 07-8387-286

This form is to be used by members of the public who feel they have suffered general or punitive damages due to the County's negligence.

Employees are not to express opinions, either orally or in writing, to claimants or their agents as to liability, investigation findings or possible claim approval.

Permanent records are available upon request from the Risk Management Division, Human Resources.

If an injury or property damage is reported which cannot be verified by the employee, and the individual concerned expresses a desire to file a claim against the County of San Bernardino, he should be advised only that:

- 1. The County Board of Supervisors have sole authority to approve payment of claims against the County over \$50,000. Risk Management Division has sole authority to approve payment of claims under \$50,000.
- 2. Complete the "Claim against the County of San Bernardino" form in triplicate (Form No. 07-8387-286). Advise the claimant to complete all blanks and attach copies of all bills or other proof of expenditure.
- 3. Submit the claim to:

Risk Management Division, Human Resources 222 W. Hospitality Lane, 3rd Floor San Bernardino CA 92415-0016

4. Forms are available at Central Stores, Purchasing.

### CLAIMS AGAINST COUNTY OF SAN BERNARDINO

Date _											
TO:	O: Risk Management Division County of San Bernardino, State of California 222 W. Hospitality Lane – 3 <sup>rd</sup> Floor San Bernardino, CA 92415-0016										
	is hereby made agains nia, as follows	st the treasury of the C	ounty of San	Bernardino, State of							
	More than \$10,000 - Municipal Cou	State the total amount Check one of the boxeurt Jurisdiction (\$10,000 rt Jurisdiction (\$25,001	es: D-\$25,000)								
Claima	ant makes the following	g statements in suppor	t of the claim:								
×1. 🕟	Name of claimant _	First Middle	Last	(Area Code and Phone No.)	·····						
2.	Address of claimant	Street	City								
3.	Notices concerning c	laim should be sent to:	·	·							
	Name	Address	Zip	(Area Code and Phone No.)							
4.	Circumstances giving	g rise to claim are as fo	llows:								
5	Date, Time and Place	e (city, street, cross-str	eet) damage	occurred and nature thereof:							
6.	Public property and/c	or public officers or emp	oloyees causi	ng injury, damage or loss:							
7.	Name, address and telephone number of witnesses:										
8.	Medical expenses to Estimated future med Other expenses	of claimed amount is a datedical expenses		Lost wages ————————————————————————————————————							
	Other damages										

Claimant or Representative

CLAIM FORM MUST BE FILLED OUT PROPERLY OR CLAIM WILL BE RETURNED WITHOUT FILING

07-8387-286 clmsagnstco/rmdfrms

#### PERSONAL PROPERTY CLAIM (EMPLOYEE)

Form No. 07-13351-000 Rev. 2/94

It is the policy of the Board of Supervisors, in accordance with Section 53240 of the Government Code, to extend coverage of the Liability Insurance Sub Fund to provide for the repair or replacement of employee's personal property necessarily worn or carried by the employee that is lost or damaged in the line of duty without fault or negligence of the employee.

Reimbursement for repair or replacement of personal property may be made when the loss or damage is caused by <u>peculiar circumstances</u> arising out of the course of employment.

No reimbursement may be made for ornamental or jewelry items except for depreciated, functional value of watches, eyeglass frames and the like.

Reimbursement for loss or damage of personal transportation vehicles is not covered under this policy but is provided under Mileage Reimbursement in the County Travel Code.

Claims for reimbursement shall be filed on the "Personal Property Claim (Employee)" Form No. 07-13351-000, Rev. 2/94, along with all necessary receipts for repair or replacement.

Forward all damaged items via interoffice mail to Risk Management to ensure processing of your claim.

#### INSTRUCTIONS TO CLAIMANT

Complete Sections 1, 2, and 3 of this form.

**Section 1 - Claimant Information.** This section is self - explanatory. The information is necessary for processing your claim.

Section 2 - Narrative Description of Incident and Damage. Explain the circumstances which caused the incident and damage to occur, including (1) the date, (2) the time of day, and (3) location of the incident. Attach documents which substantiate the claim such as receipts showing actual purchase price of the lost or damaged item, industrial accident reports, arrest reports, repair orders for equipment which malfunctioned, and formal or informal incident reports. If there were witnesses to the incident, list their names, titles and phone extensions in the spaces provided.

**Section 3 - Employee Valuation and Claim.** In all cases of loss, the following columns must be completed:

Date of Loss

Item

Repair or Replace (Is the article to be repaired or replaced?)

Place an "X" in the appropriate column.

Date of Purchase

Purchase Price (Original cost of article)

Repair or Replacement Cost

(Repair Cost - The cost to repair the article)

(Replacement Cost - the cost to replace the article with a new article of comparable quality)

Amount of Claim

If the claim is for an article of clothing, indicate the condition of the clothing at the time of loss by placing an "X" in the condition column which applies:

Excellent: Having the appearance of an exceptionally well-cared-for article which belies

its age.

Average: Having an appearance expected of an article which has had reasonable use

considering its age.

Poor: Having the appearance of extensive use but not of abuse, evidence of

repairs, the presence of well-worn areas and permanent discoloration provided that they do not destroy the usefulness of the article, are

considered to be signs of poor condition.

NOTE: The condition column should only be completed when reimbursement is sought for articles of clothing.

If more than one article was lost or damaged, list them in the extra space provided or attach an extra sheet if necessary. Be sure to sign and date your claim. Keep the original copy for yourself and then submit the claim to your supervisor for review and processing.



### PERSONAL PROPERTY CLAIM (Employee)

Note: Damaged items must accompany claim. See page 2 side for instructions. County of San Bernardino RISK MANAGEMENT DIVISION 222 West Hospitality Lane, 3rd Floor San Bernardino, CA 92415-0016 (909) 386-8631

······································			1 - 3 -						(909)	300-00	<u> </u>			
1. CLAIMAN	NT INFO	RMATION												
NAME								D,	ATE OF H	IIRE				
OCCUPATION	ONAL GF	ROUP					JOB CLA	B CLASSIFICATIONS EMPLOYEE NO.						<b>)</b> .
DEPARTME	DEPARTMENT DIVI													
LOCATION	ADDRES	SS									WOR	RK PH	HONE	<u> </u>
HOME ADDI	RESS										НОМ	E Ph	IONE	
2. NARRAT combativ			CIDENT AND	DAMAG	E (Incl	lude na	me of res	ponsible party, if a	pplicable	; i.e., do	g own	er, p	atien	t,
WITNESS		NAME OF WITN	ESS			ADDR	ESS			PHON	E			
TO INCID	ENT													
3. EMPLOY	EE VAL	UATION AND CL	AIM											
	,										CON	IDITI	ON	
DATE OF LOSS		ITEM (Include Bran	d)	REPAIR	REPLACE	DA DAN	RCHASE TE OF MAGED TEM	PURCHASE PRICE OF DAMAGED ITEM	REPA REPI CC	ACE	Excellent	Average	Poor	AMOUNT OF CLAIM
							OF CLAIN							
fault of my	own, wh							nal property loss a rdino, that the abov						
		Signature	of Claimant					-		V	Ĺ	Date		
		4. DEPARTMEN	IT HEAD REV						SK MAN	4 <i>GEMEI</i>	VT DIV	ISIOI	٧	
satisfaction.	I have re	urrounding this cla eviewed policy 06 omplies with policy	-07 of the Cou				this Pay	Approve   yment Authorized \$  mments			***************************************			
Recommend	lation	☐ Appro	ved E	Denied	t									
Department Head Approval Date By:					Su <sub>l</sub> By:	pervising Liability Cla	aims Rep	resentati	ve App	roval		Date		
					AL	JDITOR'	'S USE O	NLY						
Acc	ounting (	Code	Amount					APPROVED:						
FUND	DEP	r ORG						LARRY WALK	ER, Audi	tor/Cont	roller			
								Ву				,	Dep	uty
												•		

07-13351-000 Rev. 2/94 rmdfrms/prnslpro.doc

DISTRIBUTION: Original- Employee First Copy – Department Second Copy – Risk Management Division, Human Resources

### County of San Bernardino Risk Management Division HAZARD REPORT

Form No. 15-18582-000

The instructions for completion are on the reverse side of this form.

This form is the tool for employees, supervisors or managers to report safety hazards. imminent hazards which endanger County employees or the public should be immediately telephoned to Risk Management at (909) 386-8624.

After hours, call the Comm Center at (909) 356-3811 and ask them to contact appropriate Risk Management staff.

#### HOW TO COMPLETE HAZARD REPORT

Form No. 15-18582-000

The purpose of the Hazard Report (Form no. 15-18582-000) is threefold:

- To provide all County employees a formal method to report unsafe facility/work conditions and job practices, either real or perceived.
- 2. To provide management a formal method to document corrective action taken on all reported unsafe conditions and/or practices, as well as a method to solicit aid or input from outside the department in correcting conditions and practices.
- 3. To notify appropriate individuals outside the reporting department that a condition or practice exists which requires assistance in resolving.

#### ROUTING

- Originating department is to maintain canary copy. Its purpose is to diary the condition for department management control as well as to provide permanent documentation that reporting and correction of unsafe situations is occurring.
- 2. Originating department forwards pink copy to Facilities Management for information and/or action as is appropriate. Facilities Management forwards pink copy to Safety Section/Risk Management Division following correction.
- 3. Originating department forwards white copy to Safety Section/Risk Management Division. Safety Section will log condition, recommend and monitor correction, and de-log as condition is resolved.

#### Top Portion of Form - For Employee and Department Use

1.	REPORTING EMPLOYEE	Full name of individual completing report. Reporting employee may exclude name if anonymity is desired. However, experience has shown that anonymously reported practices and conditions are frequently difficult to identify and correct.
2.	DATE	This should reflect the date report is actually completed.
3.	DEPARTMENT	Name of department where hazard exists.
4.	LOCATION	Complete address of where condition exists.
5.	DESCRIPTION	Report must include a description of condition or practice in detail sufficient to identify the problem.
6.	CORRECTIVE ACTION	An appropriate member of department management should review the report prior to routing. If condition is corrected within the department, report should so indicate. If necessary corrective action is beyond the scope of departmental correction, report should be routed with departmental recommendations.
7.	DATE CORRECTIVE ACTION TAKEN	This should reflect date that any actual departmental corrective action was completed.
9.	PHONE NUMBER	This should include a telephone number of the individual whom Safety Section can call relative to the hazard.
10.	ANONYMITY	The purpose of the Hazard Report is to assure that unsafe conditions are corrected. It is for this reason that department management must be the initial step in form routing. Employees who perceive the need for anonymity are to direct the form to management in such a way as to protect their identity. Employees in such circumstances will need to xerox the report if a copy is desired.

#### Lower Portion of Form - For Facilities Management Use

1.	DATE	This should reflect date that report of corrective action is being prepared. The narrative of corrective action should include date of such correction.
2.	CORRECTIVE ACTION	This section should include a complete report of all action taken to correct condition.
3.	SIGNATURE	Signature of Facilities Management Supervisor responsible for corrective action.
4.	TITLE	Title of Supervisor signing report.



## County of San Bernardino RISK MANAGEMENT DIVISION

### **HAZARD REPORT**

Reporting Employee (Optional)			Date
Department			
Location of Condition			
Danistis at Handric Condition at H	- f- Dii		
Description of Hazardous Condition or Ur	isare Practice:		
Corrective Action Taken or Recommende	ed:		
Date Corrective Action Taken	Signature		Phone Number
Date Corrective Action Taken	Signature		Friorie Number
DO NOT WRITE E	BELOW – FO	R FACILITIES MANAGEMENT USE ON	LY
THE FOLLOWING CORRECTIVE ACTIO	N HAS BEEN	COMPLETED:	
	<del></del>		
	****		
Title		Signature	

DISTRIBUTION:

Original – Risk Management First copy – Originator Second copy – Facilities Management

15-18582-000 rmdfrms/hazards.doc

### HOW TO COMPLETE WORKPLACE THREAT INCIDENT AGAINST COUNTY OF SAN BERNARDINO EMPLOYEE

Form No. 10-19964-000

County of San Bernardino Board of Supervisors policy 09-08 requires that written documentation be prepared on all incidents of violence or assaultive behavior, either real or perceived, direct or indirect, verbal or physical, against County employees.

Form No. 10-19964-000 which is available from Central Stores, has been developed to document both threatening and assaultive incidents.

The information requirements of the form are self-explanatory:

Items 1 through 3	Identify the individual who has threatened or assaulted an employee.
Items 4 through 7	Describe the threat or assault.
Items 8 through 13	Identify the employee as well as provide other contact information.

The document is to be immediately prepared by the threatened or assaulted employee's immediate supervisor. It requires no signature, and departments must not establish internal procedures that will delay the prompt distribution of documentation to Human Resources and Risk Management Division, Safety/Loss Prevention Section, via Interoffice Mail.

The form presumes, and should follow, telephone reporting to appropriate levels of Department Management, and the Personnel Officer and/or Safety personnel depending upon the nature of the incident and need for consultation, guidance or assistance.



### County of San Bernardino

### WORKPLACE THREAT INCIDENT AGAINST COUNTY OF SAN BERNARDINO EMPLOYEE



Name of individual threatening County emp	ployee:		
Perpetrator's relationship to County:			
Physical description: Height	Weight	Hair	Eyes
Ethnicity SSAN		CDL	DOB
Address/Phone:			***************************************
Distinguishing Characteristics			(Attach Photo if poss
Location of threat			
Date	Time		
Circumstances of threat & who heard it			
		, , , , , , , , , , , , , , , , , , ,	
	and the second s		
Exact words of threat			
Threatened County Employee		Phone	
Department		Phone	
Supervisor		Phone	
Work Address		_	
<b>Building Safety Coordinator</b>		Phone	
Employee's home telephone		Cell Phone	
Additional comments		_	
-		nemananan eri	
			MA TO THE RESIDENCE OF THE PROPERTY OF THE PRO

### HOW TO COMPLETE WORKPLACE THREAT MITIGATION REPORT

(Form No. 15-19965-000)

The California Labor Code and Title 8 California Code of Regulations, General Industry Safety Orders, require prompt mitigation of hazards to employee safety and health.

Form 15-19965-000, which is available from Central Stores, has been developed to document the mitigation or abatement of a hazard to employee health and safety resulting from threats of assaultive behavior against employees.

As with the previously reviewed Workplace Threat Incident Report, (page 171) this Mitigation Report presumes telephone reporting and the appropriate involvement of senior Department Management, the Personnel Officer and/or the Risk Management Division Safety/Loss Prevention Section.

The form is self explanatory, is the approved method of documenting key mitigation or abatement actions which must be considered, and **requires the Department Head signature**, and the signatures of the Personnel Officer and/or Safety personnel, depending upon the involvement of the latter two individuals.



### COUNTY OF SAN BERNARDINO WORKPLACE THREAT MITIGATION REPORT

Name of threatened em	nployee			
Department				
Supervisor				
Work address				
Work telephone		Home tele	phone	
ASSESSMENT BY:				
Department Head	Name		Telephone	
Personnel Officer	Name		Telephone	
Risk Mgmt/Safety	Name		Telephone	
RECOMMENDED ACT	TION:			
☐ Armed security at w	vorksite	Date initiated _		
☐ Surveillance of perp	petrator	Date initiated _		
☐ Area lighting		Date initiated _		
☐ Accompaniment to a	and from car	Date initiated _		
☐ Change in work hou	rs	Date initiated _		
☐ Change in parking lo	ocation	Date initiated		
☐ Surveillance of emp	bloyee	Date initiated _		
☐ Change in work loc	ation	Date initiated _		
☐ Injunction against p	erpetrator	Date initiated _		
☐ Buddy system		Date initiated _		
Other				

DISTRIBUTION: Original – Risk Management Division/Safety Section First copy – Human resources Personnel Officer Second copy – Department

15-19965-000 rmdfrm/wrkplcthrt.doc



### County of San Bernardino BLOODBORNE PATHOGEN & TUBERCULOSIS EXPOSURE REPORT

INSTRUCTIONS ON REVERSE SIDE)

1. SECTION 1		(MSTROCHONS ON REV			
2. Employee Name	2. Employee Name			4. S.S.N.	
5. Home Address (no., street, apt. #)			1	6. Home Phone	
7. (city, state, zip)			8. Work Phone		
9. Hire Date	10. J	ob Classification		11. Employee #	
12. Dept. Org. Code	13. 🗅	Pept. Fund 14	. Sub Fund	15. Location Code	
16. Department Name (specify section)					
17. Dept. Mailing Address (n	umber, street, c	ity, zip, mail code)			
18. SECTION 2	BLOO	DBORNE PATHOGEN EXPO	SURE SECTION		
20. If SHARPS: Type and B	rand of Sharp	hing  □Article  □Sharps  □No If no, corrective action taken:		additional sharps information or	n reverse side
22. PPE Used: Gloves	☐Gown ☐	Apron Goggles Eye Shield	Other (specify)		
23. Exposure Transmission:	☐Skin w/brea	ak	t Eye	ner (specify)	
	inger 🔲 Hand	I □Arm □Face/Head □Torso			
26. Substance Involved:	Blood	en   Vaginal Secretions   Cere	ebrospinal Fluid	specify)	
27. How Exposed:					
28. Extent of Exposure (expla	ain and quantify	if possible):	-		
29. Actions taken following e	xposure: DW	ashing ☐First Aid ☐Irrigation	Other (specify)		
Is the source known?	□No □Yes	If yes, source name, date of birth:			
Source Status (to be complete 31.		cility or Risk Management ONLY)  HBV- HIV+ HIV-	Unknown		
32. <b>SECTION 3</b>		TUBERCULOSIS EXPOS	SURE SECTION (AIRI	BORNE)	
33. How exposed:					
34. Length of time in contact					
35. Is the source known	<del></del>	☐Yes If yes, source name, date	of birth		
Source Status (to be completed by treating facility or Risk Management ONLY)  36.					
Land 1		TION/FOLLOW-UP TREATMEN			
background information relative to the	e incident. All billi	ow-up as provided by San Bernardino Coungs for services are to be sent to: 12 W. Hospitality Lane, Third Floor, San Be		as been previously provided. Above	e you will find
Supervisor's Name (type or print)		Supervisor's Signature	Phone	Title	Date

DISTRIBUTION: Original – Treating Facility Second Copy - Risk Management

#### Instructions for completing the Bloodborne Pathogen & Tuberculosis Exposure Report

This report includes medically sensitive information and is to be prepared and handled in strict confidence. Only these two pages are to be prepared as follows:

- 1) The employee delivers the first page to the approved medical facility to which he or she has been referred for evaluation and follow-up.
- 2) The second page is to be sent in a sealed envelope marked. "Medically Sensitive and Confidential Information to be opened by Addressee only", to Human Resources/Risk Management Division, Attn: County Safety Officer, mail code 0016.
- 3) Additional information and requirements are contained in the Employee Safety & Health Manual in accordance with the California Code of Regulations, Title 8, Section 5193. Questions regarding this form and other safety related matters should be directed to the County Safety Officer.

This report is not to be copied or duplicated, nor is the information contained herein to be maintained in any fashion other than described above without the expressed written permission from the County Safety Officer. The information contained in the report is not to be released in any manner or to any person, other than outlined above, without review and approval by County Counsel, San Bernardino County. If the exposed employee desires to maintain a copy of this report, such copy is to be provided by the treating medical professional. San Bernardino County employees are hereby advised that in maintaining a personal copy of this report, they assume personal liability (both civil and criminal) for any release of confidential information on the source individual that may result from maintaining such personal copy.

#### Instructions - Complete Section 1 (1-17) for all exposures.

- 1-11 Self explanatory.
- 12-15 This information can be obtained through your Human Resource Officer or Payroll Clerk.
- 16-17 Specify your department, section and mailing address with mail code.

### Complete Section 2 (19-31) for Bloodborne Pathogen exposures

- 19. What was contaminated on the source that came in contact with the employee.
- 20. Sharps if a sharp (needle, razorblade, knife, etc.) was involved during the exposure and was being used in a controlled environment (hospital, medical aid, clinic, etc.), then document the type, brand and model of the sharp (e.g. 18g needle/ABC Medical/"No stick" syringe) and complete the following information:

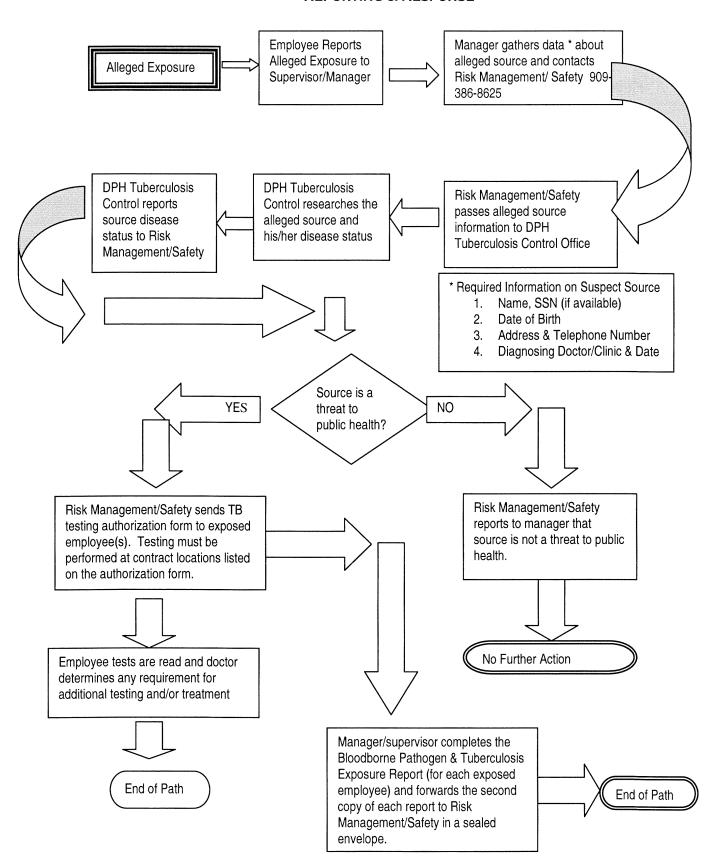
Additional Sharps Information
A. Did the device being used have engineered sharps injury protection? $\square$ Yes, continue $\square$ No, skip to question B
1. Was the protective mechanism activated? ☐ Yes ☐ No
2. Did the exposure incident occur: ☐ Before ☐ During ☐ After activation
B. <u>Exposed Employee</u> : If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury? Explain:
C. Exposed Employee: Do you have an opinion that any other engineering administrative or work practice control could have prevented the injury? Explain

- 21. Self explanatory.
- 22. Indicate what type of Personal Protective Equipment (PPE) was being worn while performing the procedure at the time the employee was exposed.
- 23. Indicate how the fluid or blood got into the employee's body. For example, blood in the eyes, puncture with a sharp, blood on skin that had a cut or scab, etc.
- 24-25. Indicate which part of the body was exposed.
- 26. Indicate what type of substance from the source individual came in contact with the employee's body part.
- 27. Exactly what was being done when the exposure occurred? For example, drawing blood, patting down a suspect, picking up a syringe with hands, etc.
- 28. Examples of Descriptive Terms: 2 drops or a quart of blood, a superficial or deep cut or puncture, etc.
- 29. Indicate what was done after the exposure to help the employee remove the substance involved.
- 30. Self-explanatory.
- 31. The treating facility or Risk Management will complete this section when applicable.

#### Complete Section 3 (33-36) For Tuberculosis exposures

- 33. Exactly what was being done when the exposure occurred? For example, transporting the source in a vehicle, entered the room to deliver a tray, etc.
- 34. Indicate the span of time the employee was in contact with the tuberculosis patient; e.g. 5 minutes, 5 hours, etc.
- 35. Self explanatory.
- 36. The treating facility or Risk Management will complete this section when applicable.

### Tuberculosis Exposure REPORTING & RESPONSE



Forms/Tb.exp.flow.v1.1.031403.doc

### HOW TO COMPLETE HEPATITIS B VACCINE AUTHORIZATION

Form No. 04-19404-000

With the concurrence of Risk Management Division/Safety Section, employees identified as working in classifications, or at job tasks, which have more than an ordinary possibility of bringing the employee into contact with human blood or specifically identified other body fluids, which are sources of Hepatitis B Virus, are to be offered immunization from the virus.

Once employees in job classifications have been so identified by departments and Risk Management Division/Safety Section, and employees have accepted the offer of immunization, individual supervisors are authorized to refer employees to **selected medical facilities** for administration of vaccine.

- 1. The first line of the form must be addressed to the medical facility selected.
- 2. The second line must include the employee's PRINTED name, job title and social security number.
- 3. Indicate that the billing detail is to be sent to:

Risk Management Division Attention: Safety Section 222 W. Hospitality Lane, 3rd Floor San Bernardino CA 92415-0016

- 4. Provide the identifying information requested at the bottom of the form.
- 5. Distribute as indicated.
- 6. Advise employee to take authorization and white copy of the Bloodborne Pathogen & Tuberculosis Exposure Report to the medical facility selected.

### **County of San Bernardino** CAO/HUMAN RESOURCES **RISK MANAGEMENT DIVISION/SAFETY SECTION**

### **HEPATITIS B VACCINE AUTHORIZATION**

To:	Address	s	
		SSN	
Name of Employee	Job Title	Management of the first term of the constitution of the constituti	
has requested immunization against	Hepatitis B.		
	s patient to assure the full series is co o proceed with the series, please cor		
Upon completion of the immunization address shown below with a copy to	n series, please provide documentati :	on of completion to the	billing
Attr 222	man Resources/Risk Management D n: County Safety Officer P. W. Hospitality Lane, Third Floor n Bernardino, CA 92415-0016	ivision	
Billing detail to provided to the Could Billing detail to be provided to:	nty Officer (address above)		
County of San Bernardino	Department		ttention
	Берантен	7	attention
Street Address	City	State	Zip
Signed By		Department	***************************************
Title		Telephone	
Date			
	<del></del>		
04-19404-000 REV 12/02			

DISTRIBUTION: Original – Employee Second Copy – Department Third Copy – Risk Mgmt Div/Safety Section

# HOW TO COMPLETE BLOODBORNE PATHOGEN PROGRAM HEPATITIS B VACCINE DECLINATION

Form No. 04-19403-000

With the concurrence of Risk Management Division, Safety Section, employees identified as working in classifications or at job tasks which have more than an ordinary possibility of bringing the employee into contact with human blood or other specifically identified body fluids, which are sources of Hepatitis B, are to be offered immunization from the virus.

Title 8, California Code of Regulations, Section 5193, General Industry Safety Orders requires that employees who decline to accept the offer of immunization from Hepatitis B Virus must complete a Declination Statement.

The required information is self explanatory.

In contrast to the distribution instructions at the bottom of the form, which will be changed in the next revision, the original of the form is to be given to the employee, the second copy is to be retained by the department, and the third copy is to be sent to Risk Management Division/Safety Section.

## County of San Bernardino HUMAN RESOURCES RISK MANAGEMENT DIVISION/SAFETY SECTION

### BLOODBORNE PATHOGENS PROGRAM HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood, body fluids or other potentially infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood, body fluids or other potentially infectious material and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

NAME	
DEPARTMENT	
DEI AITIMENT	
SIGNATURE	DATE
DISTRIBUTION:	Original – Treating Facility First copy – Department Second copy – County of San Bernardino, Risk Management/Safety Section

04-10403 rmdfrms/blood.doc